

Backus Hospital

A Hartford HealthCare Partner

Approved
7/15/19
SHN

July 12, 2019

Susan Newton RN, B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Re: Plan of Correction in response to State of Connecticut Department of
Public Health Violation Letter, Unannounced Visit May1 and May 2, 2019

Dear Ms. Newton,

Attached please find the Plan of Correction for the above referenced Department of Public Health survey findings. This is being sent to you in accordance with instructions outlined in the letter dated June 27, 2019.

In response to the violations, attached please find our Plan of Correction in accordance with instructions outlined in the letter.

Should you require any additional information, please do not hesitate to contact me or Katie Pollard, Interim Director of Quality & Safety (860-889-8331, x 4483).

Sincerely,

Laura Currie, RN, MS

Laura Currie RN, MS
Vice President of Patient Care Services
Hartford Healthcare, East Region

Corrective Action Plan
William W. Backus Hospital
July 12, 2019
Dates of Visit: May 1 and May 2, 2019

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (i) General (6)

1. Based on a review of facility documentation, interviews with staff, and policy review, the Governing Body failed to have a system in place to monitor the contracted service for Food and Dietetic Services to ensure that appropriate actions were taken and documented when kitchen refrigerator temperatures were out of range and/or failed to have a mechanism in place to ensure that food remained safe to consume when refrigerator temperatures were out of range. The findings include the following:
 - a. The hospital's dietary department utilized a Temp Trak system to monitor the temperatures for all refrigerators and freezers 24 hours a day. Review of the Temp Trak system data identified multiple occasions when the refrigerator temperatures were not within the acceptable range of 32-45 degrees Fahrenheit (°F).

- i. Review of the Temp Trak system during the period of 4/12/19 and 4/16/19 identified that temperatures were not within the acceptable range for one or more refrigerators on 31 occasions, as indicated by the system's recently cleared (acknowledged) alert conditions.

On 28 of the 31 occasions (between 4/12/19 and 4/16/19), documentation failed to identify that staff identified the cause and/or provided remediation.

Review of maintenance work orders between 4/4/19 and 4/16/19 indicated that a work order dated 4/15/19 noted ice was forming on the fan in the dairy walk-in refrigerator. There was no documentation that identified the cause and/or remediation for 30 of the 31 alerts.

Interview with IT #1 on 5/1/19 at 11:00 AM identified that the Temp Trak system would alarm if the temperature did not meet the identified parameters (32-45°F) for one hour, and would reset automatically once the identified parameters are met for one hour. IT #1 stated that there were times when the Temp Trak system alarmed and it could be hours to days later when the alarm was acknowledged or cleared. For example, on 4/12/19 at 2:00 PM the cold prep refrigerator (vegetables/condiments) alarmed for a temperature of 47.5°F. The Temp Trak log indicated that the alarm reset itself at 5:00 PM (3 hours later); however the alarm was not acknowledged or cleared until 4/13/19 at 3:18 PM (25 hours later).

Interview with Dietary Worker (DW) #1 on 5/1/19 at 1:30 PM indicated that she checks the alarm notifications on her arrival at 5:30 AM, at 11:30 AM, 1:30 PM and the evening shift staff check prior to leaving at 7:30 PM. DW #1 indicated that if the temperatures are high (50°F or higher) she reports this to a supervisor, however, was unable to provide associated documentation for the out of range readings. DW # 1 further stated that when

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the alarm codes are reviewed she clears them and from a prepopulated list chooses the statement "monitoring status" which means she will continue to monitor. DW #1 further indicated that prior to the Dietary Supervisor leaving about a month ago, she used to keep her computer on at all times so if a temperature alarmed staff would know in real time while the department was open (5:00 AM-8:00 PM) and could check the alarm. However, since her departure there was no "real time" system in place. DW #1 stated she uses the computer for other tasks and cannot leave it on the temperature tracking system. In addition, there is no monitoring of the alarm system when the dietary department is closed.

Interview with the Dietary Director on 5/1/19 at 9:15 AM identified that the Temp Trak system is manually monitored 3 times a day. If there is a system alert staff are expected to check the temperature, clear the alert and notify maintenance staff or the supervisor of any issues.

Interview with the Executive Chef on 5/1/19 at 9:30 AM indicated that four times a day the Temp Trak system is checked by dietary office staff and if there is an alert, staff should manually check the temperature, clear the alert, and fill out a work order if there is an issue.

Review of the policy for Refrigerator/ Freezer Temperature Monitoring Maintenance indicated that food refrigeration will be between 36-40°F.

ii. Review of Temp Trak reports between 4/11/19 and 4/17/19 indicated that the sensor #222-248 (cook prep refrigerator) registered temperatures of 68 to 70°F. Review of maintenance logs and interview with the Dietary Director and the Executive Chef on 5/1/19 at 1:50 PM stated this refrigerator had been taken out of service on 2/28/19 and replaced with a new refrigerator. The Director of Dietary indicated that a Temp Trak sensor had not been placed on the new cook prep refrigerator and that refrigerator temperatures had not been monitored from 2/28/19 to 4/16/19.

iii. "Recently Cleared Alert Conditions" documentation was reviewed with the Information Technologist (IT) responsible for the Temp Trak system on 5/1/19 at 11:00 AM. Between 4/12/19 and 4/16/19, sensor 76-137 E alarmed and was cleared 11 times. Review of the facility documentation indicated that the alarm was being triggered due to high temperatures and a low battery in the sensor. The documentation failed to reflect that the low battery issue was addressed.

Interview with the Regional Director of Quality on 5/2/19 at 11:50 AM identified that the contracted service of food and dietetics is reviewed annually by the Medical Executive Committee. The System Director of Food and Nutrition meetings dated 2/1/19 and 4/5/19 identified agenda items of financial review, patient experience and operations

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update. The issue of kitchen refrigerator temperatures being out of range over time was not addressed.

The hospital discontinued the use of the Temp Trak system on 4/16/19. Facility staff began obtaining refrigerator and freezer temperatures every four hours as well as monitoring food temperatures. Repairs were made to refrigerators and freezers and staff throughout the dietary department were reeducated on food safety practices.

The following plan has been put into place:

Responsible Person: Director of Food and Nutrition

Completion date: 5/23/19

- Electronic temperature monitoring (TempTrak) was suspended on 4/16/17.
- An interim plan was put into place for manual temperature monitoring on 4/16/19. Food and Nutrition staff is now manually obtaining the temperatures of all refrigerator and freezer units upon opening and closing of the department, and the temperatures of all refrigerator and freezer units and the temperature of 2 at risk food items per refrigerator unit every 4 hours during hours of operation. The staff documents the temperature on the appropriate log with documentation of any action taken if the temperature is found to be out of range. The goal is 100% compliance for 3 months with temperature monitoring at appropriate intervals and documentation of action taken for any excursions. When that goal is reached, the frequency of monitoring will be decreased to twice daily.
- Staff is being educated on the procedure that was put into place. Education was initiated 4/16/19. Only staff who have received the education are allowed to perform temperature monitoring.
- The refrigerator noted to be out of range was removed from service immediately on 4/16/19.
- A vendor was contracted and completed a full inspection of all cold units 4/18/19 and 4/19/19
- Formal standard work is being created for the temperature monitoring process utilizing lean tools to assist in compliance and standardization of the process. Staff will be educated to the standard work. Direct observation of standard work compliance related to the temperature monitoring will be initiated weekly by the Director of Food and Nutrition or member of the management team with a goal of 100% compliance for 3 months.
- Data regarding compliance with temperature monitoring and documentation of appropriate action taken when an excursion is identified will be aggregated weekly by Department leadership. Data will be reviewed by department leadership at weekly management meetings and by the V.P. of Operations of the Contracted Service. Data will be submitted monthly to the Quality and Safety Department and will be presented to the Infection Control Committee, monthly X3 and then quarterly, and to QAPIC via the Infection Control Committee minutes.
- The Joint Review Committee, inclusive of institution and contracted service leaders, will review the contract specific indicators which will include compliance with rules and regulations for local and state departments of public health and CMS/Joint Commission regulations and the reports of all local or state health department inspections. The data will be included in the scheduled biannual QAPIC presentations by the Department of Food and Nutrition.
- On 5/13/19 a summary of the DPH findings and the action plan was presented to QAPIC.
- On 5/20/19 a summary of the DPH findings and the action plan was presented to the Infection Control Committee.

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The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3
(b) Administration (2) and/or (h) Dietary Service (1)

2. Based on a review of facility documentation, interviews and policy review, the facility failed to ensure that a comprehensive QAPI program was established for the Food and Dietetics Services department to monitor the effectiveness and safety of services with monitoring and/or responding to refrigerator temperatures that were out of range to ensure that food remained safe to consume. The findings include the following:

- a. Review of the hospital's Local Health Department report dated 8/22/18 indicated that the Hospital's walk-in cooler temperatures were above the 41 degree Fahrenheit (°F) threshold, with deli meat being 43°F. The report indicated that the items were discarded. A Local Health Department survey was conducted on 3/8/19 that identified the facility failed to ensure that cold storage met the identified parameters (below 41°F), and that the items were voluntarily discarded. A Local Health Department survey was conducted on 3/22/19 and indicated that the facility failed to ensure that cold storage met the identified parameters (below 41°F), and that numerous items were voluntarily discarded. The report indicated that a meeting with the local health department and the facility would be scheduled due to repeated critical violations. A Local Health Department survey was conducted on 4/16/19 that identified that the facility failed to ensure that cold storage met the identified parameters (below 41°F), requiring items to be discarded.

Review of the Food and Nutrition quality assurance (QA) data for 2016, 2017 and 2018 indicated that the indicators reviewed were three categories from the Press Ganey patient evaluation. The items reviewed were the quality of food, temperature of food, and courtesy of the server. Although the department had ongoing issues with maintaining appropriate food temperatures, the department's QA focused on the outcome of meals, not on the storage and preparation of the food.

- b. The hospital's dietary department utilized a Temp Trak system to monitor the temperatures for all refrigerators and freezers 24 hours a day. Review of the Temp Trak system data during the period of 4/11/19-4/17/19 identified multiple occasions when the refrigerator temperatures were not within the acceptable range of 32-45°F. Facility documentation failed to indicate steps taken to remediate the issue. Interview with IT #1 on 5/1/19 at 11:00 AM indicated that there were times when the Temp Trak system alarmed and it could be hours to days later when the alarm was acknowledged or cleared. For example, on 4/12/19 at 2:00PM the cold prep refrigerator (vegetables/condiments) alarmed for a temperature of 47.5°F. The Temp Trak log indicated that the alarm reset itself at 5:00PM (3 hours later), however the alarm was not acknowledged or cleared until 4/13/19 at 3:18 PM (25 hours later).

Interview with the Executive Chef on 5/1/19 at 9:30AM indicated that three times

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a day the Temp Trak system is checked by dietary office staff and if there is an alert, staff are supposed to manually check the temperature, clear the alert, and fill out a work order if there is an issue.

Interview with Dietary Worker (DW) #1 on 5/1/19 at 1:30PM indicated that she checks the alarm notifications on her arrival at 5:30AM, at 11:30 AM, 1:30PM and the evening shift staff check prior to leaving at 7:30PM. DW #1 indicated that if the temperatures are high (50 degrees or higher) she reports this to a supervisor, however there is no associated documentation. DW #1 indicated that when the alarm codes are reviewed she clears them and from a prepopulated list chooses the statement "monitoring status" which means she will continue to monitor. DW #1 indicated that prior to the Dietary Supervisor leaving about a month ago she used to keep her computer on at all times so if a temperature alarmed staff would know in real time while the department was open (5:00AM-8:00PM) and could check the alarm. However, since her departure there is no real time system in place. DW #1 indicated that she uses the computer for other tasks and cannot leave it on the temperature tracking system. In addition, there is no monitoring of the alarm system when the dietary department is closed.

Interview with the Regional Director of Quality on 5/2/19 at 11:50 AM identified that the contracted service of food and dietetics is not incorporated in the hospital's quality improvement council.

The facility failed to have an effective QAPI program for the Food and Dietetics Services department to ensure that food remained safe to consume when refrigerator temperatures were out of range.

The following plan has been put into place:

Responsible Person: Director of Food and Nutrition

Completion date: 5/23/19

- Data regarding compliance with temperature ~~monitoring~~ and documentation of appropriate action taken when an excursion is identified will be aggregated ~~weekly~~ by Department leadership. Data will be reviewed by department leadership at weekly ~~management~~ meetings and by the V.P. of Operations of the Contracted Service. Data will be submitted ~~monthly~~ to the Quality and Safety Department and will be presented to the Infection Control Committee, ~~monthly~~ X3 and then quarterly, and to QAPIC via the Infection Control Committee minutes.
- The Joint Review Committee, inclusive of institution and contracted service leaders, will review the contract specific indicators which will include compliance with rules and regulations for local and state departments of public health and CMS/Joint Commission regulations and the reports of all local or state health department inspections. The data will be included in the scheduled biannual QAPIC presentations by the Department of Food and Nutrition.

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The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3
(h) Dietary Service (i) and/or (i) General (6)

3. *Based on a review of facility documentation, interviews with staff, and policy review, the Director of Food and Dietetic Services failed to effectively supervise the day to day operations of the dietary department including failure to respond to out of range refrigerator temperatures to ensure the safety of patients, staff, and the general public. The findings include the following:

- a. The hospital's dietary department utilized a Temp Trak system to monitor the temperatures for all refrigerators and freezers 24 hours a day. Review of the Temp Trak system data identified multiple occasions when the refrigerator temperatures were not within the acceptable range of 32-45 degrees Fahrenheit (°F).
 - i. Review of the Temp Trak system during the period of 4/12/19 and 4/16/19 identified that temperatures were not within the acceptable range for one or more refrigerators on 31 occasions, as indicated by the system's recently cleared (acknowledged) alert conditions.

On 28 of the 31 occasions (between 4/12/19 and 4/16/19), documentation failed to identify that staff identified the cause and/or provided remediation.

Review of maintenance work orders between 4/4/19 and 4/16/19 indicated that a work order dated 4/15/19 noted ice was forming on the fan in the dairy walk-in refrigerator. There was no documentation that identified the cause and/or remediation for 30 of the 31 alerts.

Interview with IT #1 on 5/1/19 at 11:00 AM identified that the Temp Trak system would alarm if the temperature did not meet the identified parameters (32-45°F) for one hour, and would reset automatically once the identified parameters are met for one hour.

IT #1 stated that there were times when the Temp Trak system alarmed and it could be hours to days later when the alarm was acknowledged or cleared.

For example, on 4/12/19 at 2:00 PM the cold prep refrigerator (vegetables/condiments) alarmed for a temperature of 47.5°F. The Temp Trak log indicated that the alarm reset itself at 5:00 PM (3 hours later), however the alarm was not acknowledged or cleared until 4/13/19 at 3:18 PM (25 hours later).

Interview with Dietary Worker (DW) #1 on 5/1/19 at 1:30 PM indicated that she checks the alarm notifications on her arrival at 5:30 AM, at 11:30 AM, 1:30 PM and the evening shift staff check prior to leaving at 7:30PM. DW #1 indicated

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that if the temperatures are high (50°F or higher) she reports this to a supervisor, however, was unable to provide associated documentation for the out of range readings. DW #1 further stated that when the alarm codes are reviewed she clears them and from a prepopulated list chooses the statement "monitoring status" which means she will continue to monitor. DW #1 further indicated that prior to the Dietary Supervisor leaving about a month ago, she used to keep her computer on at all times so if a temperature alarmed staff would know in real time while the department was open (5:00 AM-8:00PM) and could check the alarm. However, since her departure there was no "real time" system in place. DW #1 stated she uses the computer for other tasks and cannot leave it on the temperature tracking system. In addition, there is no monitoring of the alarm system when the dietary department is closed.

Interview with the Dietary Director on 5/1/19 at 9:15 AM identified that the Temp Trak system is manually monitored 3 times a day. If there is a system alert, staff are expected to check the temperature, clear the alert and notify maintenance staff or the supervisor of any Issues.

Interview with the Executive Chef on 5/1/19 at 9:30 AM indicated that four times a day the Temp Trak system is checked by dietary office staff and if there is an alert, staff should manually check the temperature, clear the alert, and fill out a work order if there is an issue.

Review of the policy for Refrigerator/ Freezer Temperature Monitoring Maintenance indicated that food refrigeration will be between 36-40°F.

The facility failed to ensure the mechanism in place was effective and/or that the Director adequately supervised the day to day operations to address the out of range temperatures which had the potential to affect food safety.

- ii. Review of Temp Trak reports between 4/1/19 and 4/17/19 indicated that the sensor #222-248 (cook prep refrigerator) registered temperatures of 68 to 70°F. Review of maintenance logs and interview with the Dietary Director and the Executive Chef on 5/1/19 at 1:50 PM stated this refrigerator had been taken out of service on 2/28/19 and replaced with a new refrigerator. The Director of Dietary indicated that a Temp Trak sensor had not been placed on the new cook prep refrigerator and that refrigerator temperatures had not been monitored from 2/28/19 to 4/16/19.
- iii. "Recently Cleared Alert Conditions" documentation was reviewed with the Information Technologist (IT) responsible for the Temp Trak system on 5/1/19 at 11:00 AM. Between 4/12/19 and 4/16/19, sensor 76-137E

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alarmed and was cleared 11 times. Review of the facility documentation indicated that the alarm was being triggered due to high temperatures and a low battery in the sensor. The documentation failed to reflect that the low battery issue was addressed.

The hospital discontinued the use of the Temp Trak system on 4/16/19. Facility staff began obtaining refrigerator and freezer temperatures every four hours as well as monitoring food temperatures. Repairs were made to refrigerators and freezers and staff throughout the dietary department were reeducated on food safety practices.

The following plan has been put into place:

Responsible Person: Director of Food and Nutrition

Completion date: 5/23/19

- Formal Standard work is being created for the temperature monitoring process utilizing lean tools to assist in compliance and standardization of the process. Staff will be educated to the standard work. Direct observation of standard work compliance related to the temperature monitoring will be completed weekly by the Director of Food and Nutrition with a goal of 100% compliance for 3 months.
- Data regarding compliance with temperature monitoring and documentation of appropriate action taken when an excursion is identified will be aggregated weekly by Department leadership. Data will be reviewed by department leadership at weekly management meetings and by the V.P. of Operations of the Contracted Service. Data will be submitted monthly to the Quality and Safety Department and will be presented to the Infection Control Committee, monthly X3 and then quarterly, and to QAPIC via the Infection Control Committee minutes.
- The Vice President of Operations, Contracted Service will be providing additional onsite oversight, average of two days/week, to oversee leadership, provide coaching and mentoring to the Director of Food and Nutrition and the management staff.
- The Director of Food and Nutrition will conduct weekly management meetings to coach and mentor management and supervisory staff.
- A Patient Services Manager has been hired to support the Director of Food and Nutrition inclusive of supporting the ~~process~~ of temperature monitoring, response to out of range refrigerator temperatures and data collection.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2)(3) and/or (c) Medical Staff (2)(B) and/or (d) Medical Records (3), and/or (i) General (6)

4.*Based on clinical record review, interview and policy review for one of three patients (Patient #2) the facility failed to ensure that the rationale for the administration of an anti-psychotic was documented. The findings include the following:

- a. Patient #2 presented to the emergency department on 10/21/18 at 4:57 PM with shortness of

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breath. The patient had a past medical history of coronary artery disease, congestive heart failure and hypertension. The physician assessment indicated that based on a detailed exam and workup the findings were most consistent with bilateral pulmonary consolidations as well as pleural effusions consistent with early onset pneumonia.

A nurse's note dated 10/22/18 at 3:09AM indicated that the patient was increasingly anxious. By demonstrating periods of throwing his/her arms screaming and talking in a foreign language. The note indicated that Zyprexa 2.5 mg IM was administered at 3:18AM for psychotic behavior.

Interview with MD #2 on 5/21/19 at 1:30 PM indicated that he order Zyprexa 2.5 mg IM for the patient because he felt that the patient was actively delirious/psychotic. The record failed to reflect an assessment of the patient subsequent to the change in mental status by MD#2.

MD #2 indicated that he was not concerned administering the Ativan followed by the Zyprexa since the patient's respiratory status had been stable all night. Review of the clinical record indicated that at 4:10 AM blood gases were obtained and at 4:12AM CPR was initiated.

Interview with the Head of the Hospitalist Program (MD #3) on 5/2/19 at 10:15 AM indicated that he reviewed the case and felt that physician documentation was lacking. MD #3 indicated that the facility has a delirium protocol and includes the option of administering anti-psychotic medication; however he would have weighed the risks prior to administration.

Review of the Delirium protocol indicated that for non ICU patients with a positive Confusion Assessment Method (CAM) unrelated to alcohol, there are guidelines for care inclusive of suggested medications. Review of the clinical record failed to reflect that MD #2 completed a CAM assessment and/or a rationale for the use of Zyprexa in a patient over 65 years old.

The following plan has been put into place:

Responsible Person: Director, Hospitalist Program

Completion date: July 12, 2019

Measures to prevent reoccurrence:

Educational review provided to the Hospitalists:

- Following the assessment of a patient with mental status changes, the Hospitalist should document in the clinical record.
- If a provider prescribes a medication that is outside of the delirium protocol the rationale for using that medication should be documented.

Sustainment:

Random audits of 10 charts per month with a goal of at least 90% compliance for documentation of assessment of patient and documentation of rationale for use of a medication if outside of the protocol.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) (3) and/or (d) Medical Records (3), and/or (e) Nursing Service (1) and/or (1) General (6)

5.*Based on clinical record review, policy review and interview for I of 3 patients evaluated in the ED (Patient #2) the facility failed to ensure that comprehensive assessments were completed. The findings include the following:

- a. Patient #2 presented to the emergency department on 10/21/18 at 4:57 with shortness of breath. The patient had a past medical history of coronary artery disease, congestive heart failure and hypertension. The physician assessment indicated that based on a detailed exam and workup the findings were most consistent with bilateral pulmonary consolidations as well as pleural effusions consistent with early onset pneumonia.
- i. Review of the clinical record indicated that in triage on 10/21/18 at 4:58PM vital signs were obtained inclusive of a temperature that was 96.9 F. Review of the clinical record indicated that although the patient's vital signs were obtained every 1-2 hours the patient's temperature was not included in those vital signs and was assessed again until 10/22/18 at 11:00 AM that identified a temperature of 94.9 F.
- ii. The physician assessment for Patient #2 completed on 10/21/18 at 7:48 PM indicated that the patient was alert and appropriate. The clinical record indicated that on 10/22/18 at 1:50AM Ativan 0.5mg intravenously was administered. The record failed to identify the rationale for the administration of the medication and/or the patient's response to the medication. Interview with RN #1 on 5/2/19 at 2:30PM indicated that the patient was getting confused and swinging his/her legs over the rail. The record failed to reflect an assessment of the patient secondary to the change in mental status and/or a reassessment of the patient to determine the efficacy of the interventions.
- iii. Review of Patient #2's nurse's note dated 10/22/18 at 3:09 AM indicated that the patient was increasingly anxious by demonstrating periods of throwing his/her arm screaming and talking in a foreign language. The note indicated that Zyprexa 2.5 mg IM was administered at 3:18 AM for "psychotic behavior". The record failed to reflect a reassessment of the patient after the administration of the medication to determine the efficacy of the intervention. Interview with MD #2 on 5/21/19 at 1:30PM indicated that he order Zyprexa 2.5 mg IM for the patient because he felt that the patient was actively delirious/psychotic.
- iv. The Nursing notes after the administration of the Zyprexa dated 10/22/18 indicated that antibiotics were administered at 3:46 AM, the next documentation at 4:10 AM indicated that blood gases were obtained and at 4:12 AM indicated that a "pulse check" was completed and CPR was initiated.
- v. Interview with RN #2 on 5/2/19 at 8:30 AM indicated that the patient was unresponsive and compressions were started. The record indicated that CPR was continued and at 4:23 AM the patient had a pulse of 127 and a BP of 105/55.

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Review of the clinical record with the Director of Quality on 5/1/19 at 2:00 PM failed to reflect accurate documentation of the cardiac arrest. The record failed to reflect documentation of the events prior to the event.

Review of the Resuscitative Process Policy indicated that the RN assigned to the patient must document events leading up to the event and the outcome of the resuscitation. Review of the Assessment and Reassessment policy indicated each patient will have ongoing assessments by the RN as warranted by the dynamic status of the patient response. The RN will communicate any abnormal findings to the patients care team throughout the ED stay.

The following plan has been put into place:

Responsible Person: Nurse Manager, Emergency Department

Completion date: June 27, 2019

Measures to prevent reoccurrence

Emergency Department Nursing staff was re-educated via a read and sign on Documentation and Assessment Guidelines for the Emergency department inclusive of:

- Frequency of assessments/reassessments
- Frequency of vital signs-, including temperatures, following med administration as appropriate or with a change in patient status
- Documentation of interventions, including when medicating a patient and patients responses to each intervention
- A review of the current Resuscitative Process Policy was completed, validated by a read and sign.

Sustainment: Random audits of 10 charts per month with a goal of at least 90% compliance for documentation of vital signs per policy, reassessment of the patient following medication administration per policy, and documentation of events leading up to a resuscitation and the outcome.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-DS (d) Medical Records (3), and/or (e) Nursing Service (I) and/or (i) General (6).

6.*Based on clinical record review, interview and policy review for 1 of 3 patients evaluated in the Emergency Department (Patient #2) the facility failed to ensure that the clinical record reflected that a critical laboratory value was communicated to the physician and/or that a comprehensive clinical record was maintained. The findings include the following:

- a. Patient #2 presented to the emergency department on 10/21/18 at 4:57 PM with shortness of breath. The patient had a past medical history of coronary artery disease, congestive heart failure and hypertension. The physician assessment indicated that based on a detailed exam and workup the findings were most consistent with bilateral pulmonary consolidations as well as pleural effusions consistent with early onset

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pneumonia.

- i. Review of Patient #2's clinical record dated 10/21/18 at 8:04 PM indicated that the patient had a Lactic acid level of 2.4 mmol/L (normal 0.5-1.9). The record indicated that this was a critical result that was called to RN #1. In this same timeframe, the patient was also experiencing tachycardia. Review of the record with the ED Nurse Manager on 5/2/19 at 8:50AM indicated that the lactic acid level was reported at 8:04 PM to RN #1 and the record should reflect a note related to physician notification.

Interview with RN #1 on 5/1/19 at 2:30 PM indicated that he did not recall reporting of the Lactic acid level to the physician. The record failed to reflect documentation that the critical laboratory value had been reported by RN #1 to a physician. However, MD #1 ordered a redraw at 8:31 PM and MD #2 ordered a lactic acid level at 9:39 which resulted at 10:51 PM as 2.0 mmol. MD #2 stated on 5/2/19 at 1:30 PM that he saw the elevated Lactic acid level in the computer and would evaluate the whole patient prior to treatment.

- ii. Review of clinical record indicated that the patient had received Zofran 4 mg injection at 3:30 AM. The record failed to reflect the reason for the medication and/or a reassessment of the patient to determine the efficacy.

The following plan has been put into place:

Responsible Person: Nurse Manager, Emergency Department

Completion date: 7/12/19

Measures to prevent reoccurrence

Emergency Department Nursing staff was re-educated on Documentation and Assessment Guidelines for the Emergency department inclusive of:

- Critical Lab reporting process and documentation
- Assessment and reassessment of all patient responses to each intervention
- Documenting the patient status relative to the indication for medication, even though the indication is present in the order, and also the patient response to the intervention to determine efficacy

Sustainment: Random audits of 10 charts per month with a goal of at least 90% compliance for documentation of provider notification of all critical results, reassessment of the patient following medication administration per policy